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LECTURE IX.

[From Leloir's Lectures on Syphilis.]

TRANSLATED BY D. N. KINSMAN, M. D., OF COLUMBUS, OHIO.

SUMMARY, CHAPTER III.—PRIMARY SYPHILOMA (SYPHILITIC CHANCRE) CONTINUED.—DIAGNOSIS OF CHANCRE.

A. It is necessary to seek for chancre and know where to find it. Two conditions to be observed: A chancre may escape notice from its position; examples. It may elude notice because it is masked by other affections; examples. B. The chancre once seen ought to be recognized. Differential diagnosis—Chancre may be seen and not recognized. This is due to polymorphism. Two cases to be distinguished: (*a.*) It is difficult of diagnosis on account of the insignificance of the lesion, which constitutes the chancre, examples; (*b*) or by excess of lesions (erosion ulceration, neoplasm). The clinician may be led into error; examples. Conclusion. It is necessary to search for chancre, and always suspect it.

C. We must not mistake another lesion for chancre. Diagnosis of chancre from any syphiloma whatsoever. Any artificially indurated wound, the orifice of an indurated abcess, tubercular or arsenical ulcerations, furuncular or anthracoid affections, conglomerated folliculitis, *in placard*, folliculitis of the genitals, certain affections of the genitals in diabetes, chancres dependent upon acari-erosive vulvitis, examples. Differentiate chancre and chancroid, clinical anatomico-pathological differences. Comparative examination of products, by scraping the two chancres. Diagnostic importance of the absence of epithelial reticulum at the surface of simple chancre.

Simple papular chancre—Example: Importance of a knowledge of this form. Some

words on the inoculation of chancroid and chancre. Possible causes of error: Inoculation of false chancre upon bearer of syphilitic chancre. Nature of chancroid lesions. Interpretation of these *bizarre*—facts, discussions, differentiation of chancre and herpes. Table of differential characters—Fournier. New signs of great practical utility, to be added to the preceding signs. Sign of expression of juice. Anatomical reasons for this sign.

DIAGNOSIS OF CHANCRE.

We come now to the important study of the diagnosis of chancre. After what precedes, this study will be relatively short Nevertheless, gentlemen, in the diagnosis of chancre, in order to avoid great errors, it is necessary to keep constantly before the mind the possibility of a chancre upon any part of the body where a lesion may be found, whatever its aspect and upon whomsoever it may be found. In a word, gentlemen, always suspect chancre.

Here we observe, 1st, we must know how to find a chancre, once found we must not mistake it for a common or non-syphilitic lesion. 2nd. I said we must, in seeking, know how to find a chancre. Indeed, gentlemen, a chancre often eludes us because it is concealed. In this search, as you know, and as I shall say in my next lecture, the primary adenopathy is a great aid. 3rd. In certain cases the chancre is concealed, larvated, as a result of its location. The chancre may be anal or urethral, and it may be situated on the neck of the uterus, in the throat, between the toes, of which I published a curious example and to which I alluded in a previous lecture.

In order to avoid the error of diagnosis, depending upon the location of the chancre, you must remember a chancre may be situated on the external or internal integument in such a way as to be inaccessible to our investigations. You ought not only to examine your patient from head to foot, but introduce the speculum, to examine the anus, nose, etc., in their depths.

In other cases chancres are masked by other lesions so as to elude us; because it is not thought of, it is not suspected, in the apparently principal affection for which the patient comes to consult us.

Chancre may be masked by intertrigo, as you saw many months ago in an anal chancre. It may be concealed by a simple balanitis, a more or less confluent herpes, a vaginitis, simple chancre, etc. You frequently see in our ward for public women, and even in our other wards for women—and in our wards for men—patients who constitute veritable pathological museums, veritable "human orchestras" of dermato-syphiligraphy. They have the itch, lice, herpes, vaginitis; clap, and purulent intertrigo, and the chancre is found as if drowned in the midst of these lesions. Simple or inflammatory phimosis often serves to conceal infecting chancres, and it will frequently be necessary to await the resolution of the inflammation before announcing a definite diagnosis. You have under your eyes an example of this. In a word, gentlemen, we must always search behind the apparent lesion, and not limit ourselves to a single one.

B. When the chancre is in view, if you recall well its symptoms as I have described them, if you seek the characteristic adenopathy of which we shall speak, usually you will be able to make the diagnosis. But in certain cases the chancre may be in sight and not diagnosticated. This is due to its polymorphism. Here we must observe two conditions: either the diagnosis is rendered difficult from the insignificance of the lesion—the chancre is a very small and insignificant hurt, and thus confounded with a simple erosion, a tear, a balanitis (as happens frequently in the macular chancre of Besnier and Doyon) —or it is taken for a herpetic erosion a little chancroid, an aptha. We shall recur to this. These chancres have been mistaken for fissures of the anus (Ricord letters on syphilis), for simple ophthalmia, for dental ulceration (Capuron), a slight burn. You have learned that a labial chancre of a "drawer of breasts" was the cause of a terrible epidemic at Tourcoing. This chancre was supposed to be a simple burn from hot potatoes. In some cases the chancre may be a small silvery patch—for example, a "smoker's patch."

R. W. Taylor (communication to American Dermatological Association, 1883,) published an interesting note upon the peculiar aspect which the indurated chancre may assume almost at the beginning of its development. In these cases the chancre was not large, but a *tache,* the size of two pins' heads, of silvery hue, not elevated, without fissure or relief even under a lens. It seemed as if the patient had been feebly cauterized at this spot with nitrate of silver (my friend, Dr. Boeck of Christiana, has also observed this lesion at the beginning of indurated chancre). Later, in Taylor's two cases, the silvery patches extended, after some days induration occurred, then adenopathy. finally, six weeks after the roseola appeared. Therefore, be suspicious of these small, smooth, silvery lesions which resemble a slight cauterization with nitrate of silver. [I ask whether, in these cases of Boeck and Taylor, the virus at this moment had not an almost exclusive epithelial seat. I compare this form of silvery syphiloma with those small, silvery or superficial syphilomata, absolutely similar in aspect, which I have shown you on the inferior aspect of the tongue in some of our patients. But here it relates to syphilomata of the so-called secondary period. The diagnosis was impossible. Here the syphiloma simulates the chancre.]

In other cases the clinician may be led into error by the excess of its erosive ulcerative or neoplastic characters. In these cases the primary syphiloma has often been taken for a malignant tumor. Ricord, in his letters on syphilis, tells of being called in consultation in order to amputate a penis attacked with a supposed epithelioma, which some pills of the proto-iodide of mercury caused to disappear rapidly. My friend, Dr. Merklin, has published an observation of a chancre of the tonsil simulating an epithelioma of that region. Hue has published an analogous case. I saw, in 1882, in the service of Professor Fournier, a papulo-hypertrophic chancre of the upper lip of such magnitude that a physician took it for a malignant tumor, and propósed its removal to the patient. The patient declined because his means would not warrant him in undergoing the operation. The surgeon demanded one hundred francs. I saw, in 1880, while an *interne* of my regretted master, Maurice Reynaud, a chancre of the tonsil taken for a diphtheritic sore throat. My friend, Dr. Brocq, has published in the thesis of Pivaudran (Paris, 1884) a case of chancre of the tonsil mistaken for a gangrenous tonsilitis.

I have the history of a patient whom I saw in the service of

Professor Fournier, in March, 1884. He had a chancre the size of a dime with strongly indurated base at the palpebral fissure of the right eye. This was mistaken by a distinguished surgeon for a lachrymal fistula. This supposed fistula was excised and cauterized by the surgeon. Finally chancres have been mistaken for chancroids, for ulcerated and non-ulcerated gummata, etc. I could not, if I would, enumerate the diverse and various lesions with which chancres may be confounded. Therefore, gentlemen, hunt for chancre and look for it everywhere.

C. Reciprocally, you must not mistake an entirely different lesion for a chancre, for very different lesions may simulate it well. In pointing out to you some among others, I will show how the opposite error may occur, and this paragraph is, therefore, the reciprocal and complement of the preceding.

(a.) Some syphilomata may be taken for chancres when they are situated on the genitals. These syphilomata, without regard to the age of the pox, may simulate chancres. I can dwell upon this no longer, having already sufficiently discussed this subject under the head of chancriform syphilomata. You have seen lately in our polyclinic a simple erosion of the balano-preputial fold, irritated by untimely cauterization, simulate an infecting chancre, so as to be mistaken. In this case it was necessary to learn the history before a diagnosis could be made. I have the history of a patient seen in October, 1884, in the service of Professor Fournier, who had, at the level of the seventh cervical vertebra, a simple wound the size of a dime, following repeated blows of the burden which he bore upon the upper part of his back and neck. Now the ulceration of this simple wound showed how this could be mistaken for an ulcerated cutaneous chancre. The presence of a chain of ganglia, which entered the supra-clavicular triangle, having all characteristics of the primary period, rendered the diagnosis still more difficult. Professor Fournier himself hesitated some days. According to Zeissl, the wound consecutive to circumcision may sometimes simulate the primary syphilitic accident. You see the importance of this fact.

I showed you a month ago in our ward (St. Come) the indurated orifices of a peri-vulvar abcess, also of the vulvo-vaginal gland, which could have been mistaken, upon superficial examination, for an infecting chancre. More recently yet have I shown you a patient in ward (St. Henri) in whom the ulcerated orifice of a perineal abcess simulated an infecting chancre so closely that a diagnosis could not be made for some days. This lesion was modeled by M. Hervez—(No. 89, female cases). Tubercular ulcerations of the tongue and penis have been seen simulating an infecting chancre (Jullien). You know that in arsenical poisoning ulcerations may occur upon the genitals, which simulate and are mistaken for infecting chancres and erosive papules. These ulcerations have been studied by Blandet, and especially by Bazin (artificial cutaneous affections). But these arsenical chancres, as they are called, are not accompanied by adenopathy, they are multiple and coincident with other more or less characteristic eruptions. Certain furuncular or anthracoid affections of the skin may in like manner simulate the primary syphiloma. Bazin and Maurice have published such cases. Some varieties of conglomerated peri-folliculitis of the skin constituting a special form of dermatitis, of which I first gave an anatomical and clinical description (H. Leloir Annales de Dematologie, 1884. Upon a peculiar variety of conglomerated peri-folliculitis in placard), sometimes have presented a likeness to infecting chancre. I present you a patient bearing upon the cutaneous surface of the prepuce, a follicular lesion of a sebaceous gland which presents a certain analogy with an ecthymatous infecting chancre. M. Harvez has made a fine model of this which see (117, cases of males). I observed, some time ago, in one of my clients whom I was treating for diabetes, a deep ulceration of the balano-preputial fold, which rested upon a true neoplasm, a true induration the size of a nut which would be mistaken for a syphilitic induration, were it not for its long period of evolution and the absence of adenopathy. Professor Verneuil, to whom I sent this patient for an operation, told me he had often observed similar indurations in diabetes. I operated upon this patient with Professor Verneuil, and the histological examination of the callosity removed showed that it was a tumor, presenting the histological charac ters of certain cutaneous keloid2. I can dwell no longer on this interesting observation, of which I have already spoken elsewhere.

As Besnier and Doyon have well said in their notes to the translation of Kaposi, "in divers points, especially on the areola of the breasts and on the penis, the irritation of acari is propgaated to the superficial vascular net work of the skin to the extent of producing true indurations which may ulcerate (acarian chancres) and simulate syphilitic chancres—(dwarf chancres)." You have seen good examples in my service, but you have also observed that the presence of the other lesions of the itch, mysign of "expression of juice," the absence of adenopathy, or where the latter exists, its inflammatory characters, etc., enable you always to fix the diagnosis.

The diagnosis is rendered more difficult at times, in an anti-pruriginous itch, a form which is not so rare as you might think. (This itch has been well described by my pupil and friend, Dr. Jouanaud, in a thesis I assigned him. (De la gale aprurigineuse). Paris, 1883.

In the preceding cases a minute examination will frequently permit us to find the factor for differentiation, in the concomitant adenopathy and characters of the lesion. But there are some cases in which the diagnosis is impossible since the most accomplished syphiligraphers have failed.

Thus Fournier tells us in his lectures upon syphilis in the woman, that he had been commissioned with Dr. Bergeron to examine a little girl supposed to be the victim of an attempt at rape, and infected during this attempt. This little girl had a lesion upon the vulva, which after a careful examination Fournier and Bergeron absolutely considered a chancre. Luckily they refused to certify so, and the subsequent evolution of the affection demonstrated that it was not an infecting chancre, but a peculiar form of erosive vulvitis.

I terminate the diagnosis of chancre with the differential diagnosis of two affections, with which it is frequently confounded, and of which the diagnosis is often most difficult. I mean the diagnosis of infecting chancre from chancroid and herpes.

V. Diagnosis of chancroid. Omitting the diagnostic signs which are drawn from the fact that chancroid is never located so to speak on the head, omitting also the signs drawn from the later evolution of the lesion, from confrontation, I place before you the following tables taken from Fournier's lectures upon syphilis in which the differential characters of chancroid and chancre are admirably sketched.

	SIMPLE CHANCRE.	SYPHILITIC CHANCRE.
I. Number of lesions.	Almost always multiple often confluent.	Often single, rarely multiple, never confluent.
II. Appearance of ulcer	1 A true ulcer sunken, excavated.	1 Lesion habitually flat, often elevated and papulous, rarely ulcerated.
	2 Borders perpendicular, abrupt, open.	2 No borders, contour adherent, frequently elevated in a crown.
	3 Base unequal, anfractuous	3 Base smooth, varnished, shining, glistening.
	4 Yellowish lively tint.	4 Gray red, flesh color, a dark deep hue.
	5 Abundant secretion of true pus.	5 Slight secretion of sero-sanious fluid rather than pus.
III. Base.	Base soft, offering a diffuse inflammatory renitence.	Base is indurated in various degrees.
IV. Ganglia.	No bubo—if any it is simple inflammatory.	Bubo constant, indolent, non-inflammatory most frequently many ganglia are involved.
V. Experimental criteria.	Pus inoculable upon patient.	Pus not inoculable upon patient.

In my opinion we may add to these differential signs, that the infecting chancre is not transmissible (to the present at least) to animals, while the chancroid is transmissible, although with difficulty. Besides, I think in some cases the histological examination of the scrapings of the surface of the sore may have a certain utility in diagnosis. If you examine an infecting chancre, a gray diptheroid erosion, you will find, as I have shown you, in the product of scrapings, the debris of false membranes, arising from cavitary alteration of the epithelium which comes from the surface of the chancre. In the chancroid, on the contrary, as there is ulceration, and as always happens when there is ulceration of the surface, there is no epithelium.

You will simply find in the product of scrapings more or less altered lymphatic cells, the dissociated debris of the connective tissue of the skin, but no false membranes and no epithelial reticulum. These preparations and drawings show you how chancroid differs histologically from infecting chancre. Compare this figure which represents a section of a simple chancre with the preceding figures of chancre and the differential anatomical character will appear immediately.

My master, Cornil, has perfectly established the characters of chancroid and infecting chancre in his lectures on syphilis. Here is what he says: "On the one hand, in infecting chancre we observe sclerosis of the dermo-papillary tissue and thickening of the walls of the vessels. The superficial epithelium and the mucous body are present in part, the scanty secretion contains a relatively small number of lymphatic cells. On the contrary, in the chancroid we have a growing crater, resulting from the rapid and complete destruction of the superficial, and deep layers of the epidermis, and from the progressive suppurative melting of the papillary and dermic layers. The papillæ connective tissues and sub-dermic tissues are transformed into fleshy granulations in which the vessels are not only sclerosed, but the fibrous network is dissolved and destroyed." You see, therefore, there is an absolute difference between the two chancres. The one is a tumor, an eroded or ulcerated syphiloma, the other an ulcer. In some cases, rare moreover, of which you have seen a good example in this service, the chancroid may take on a papular aspect. In these cases, as you have seen in our patient, chancroid appears in the form of small red papules large as a lentil. Some may only be eroded, others may present at their center a small pustule, or a gray, cup-shaped erosion. The excellent water color which I exhibit to you was made by M. Nollet, a pupil in the service, and gives an exact idea of these lesions to those of you who have not seen the patient. But these papular chancroids were not indurated. Besides, these were found on the internal surface of the prepuce and in the balano-preputial fold characteristic chancroids—but the engorged inguinal lymphatic ganglia present none of the characteristics of primary adenopathy, and finally inoculations from papulous lesions have given positive results. A knowledge of these papulous chancroids is of great diagnostic importance and it is possible that cases of this kind serve as arguments for the *Unicist.* This observation will be published.

In the preceding differential diagnosis of chancroids from chancre, I have insisted but little upon the major differential characteristic of the constant possibility of inoculating the bearer with chancroid, and the impossibility of inoculating the bearer with chancre. Yes, gentlemen, a thousand times yes, we may say, chancroid is inoculable upon the bearer, not only once, twice, a hundred, but an infinite number of times. I wish no better proof of this than the auto-inoculations of Auzias Turenne and Lindwurm, who in a vain endeavor to produce syphilization inoculated from more than twenty-two hundred chancres.

You have moreover observed in my service that chancroid of inoculation is never wanting when the operation has been well done. On the contrary, the infecting chancre is not re-inoculable, and this proposition may be established as an absolute rule. This you have likewise observed in my service. Therefore, yes—a thousand times repeated, the non-inoculability of the infecting chancre is of major importance and may be considered pathognomonic.

It is now necessary to advise you of a possible source of error. In some cases the pus of infecting chancres inoculated upon its bearers may produce a pustule, which may abort in a few days, as you have seen in cases in my wards, or rupture and leave a more or less persistent ulceration. This consecutive ulceration may sometimes simulate a chancroid to such an extent, that Clerc, who was the first to call attention to this fact, gave it the name *chancroid.*

Ricord has published some cases in his lectures which tend to show that this chancre of syphilitic subjects, with soft base, may be transmitted under the form of chancroid or it may be transmitted to a sound subject as an infecting chancre.

I cannot dwell longer on this question which has been the point of departure for numerous discussions upon the part of the Unicists. It seems possible to sum up the matter thus; when we take into consideration the relatively frequent existence of mixed chancres, demonstrated by Rollet, when we recall the experiments of Vidal, Pick and others upon lesions consecutive to inoculations with certain kinds of pus, and finally the very interesting researches of Tarnowski on irritation and production of syphilomata thereby. It seems to me that when the inoculation of chancre upon its bearer produces an ulceration recalling that of chancroid, it is probable that the sore from which the material for inoculation was taken was a mixed chancre.

If, then, one inoculates the products of this chancre with soft base, this chancroid, from this chancre inoculated upon a sound subject, two results may take place. Either the inoculation will only give rise to a chancroid, or the chancre inoculated upon a sound subject will be followed by constitutional symptons. In the latter case it is more than probable that the inoculated chancroid of the first subject, the bearer of a mixed chancre, had determined by its presence, by irritation, the appearance of a syphiloma clinically more or less perceptible.

It is not therefore properly speaking a new chancre, but the calling forth of a syphlloma by irritation. We can readily see how more or less perceptible particles of this syphiloma, and sometimes even the blood, can reproduce an infecting chancre when inoculated upon a sound subject. What takes place, as you have seen in my wards, when inoculation with the products of the secretion of a syphilitic chancre, produces upon the bearer of this chancre an ecthymatous pustule, followed sometimes by an erosion or a more or less persistent ulceration.

A phenomenon is produced similar to that which we observe when the pus from an ecthymatous or impetiginous pustule has been inoculated (as has been well shown by E. Vidal and subsequently by Tanturri) or when any pus whatever has been inoculated, as has been shown by my friend Pick of Prague. In a word there is a pustule of simple ecthyma produced, an intra-epidermic suppuration by the inoculation of simple pus. You have seen examples of this in my ward and at my polyclinic. These lesions have nothing specific about them ; but we can readily see how the irritation of this simple lesion, as Tarnowski remarks, may determine *in situ* a syphiloma, and that the products of this syphiloma, mixed with those of this simple intra-epidermic suppuration may when inocnlated upon a sound subject produce infecting chancre. These are very interesting questions which we are studying at this moment, in our service, and would furnish matter for a thesis. You see that the differential diagnosis of chancroid and chancre has carried us a little farther.

We begin now a not less difficult diagnosis, that of chancre from herpes. This diagnosis is of highest importance, as you will daily observe. The following table, taken from Professor Fournier, will assist you greatly:

	HERPES.	CHANCRE.
Three almost constant differential signs.	1. No ganglionic enlargement.	1. Constant adenopathy, indolent, hard, persistent, usually many ganglia are involved.
	2. Base, soft, not indurated.	2. Base, indurated.
	3. Contour of erosion many circled formed by regular segments of small circumference.	3. Contour never present, never regular segment of small circumference, as in herpes.
Evolution.	1. Rapid limitation.	1. Limitation not so rapid.
	2. Healing rapid.	2. Healing usually slow.
Inconstant signs of less value.	1. Pruriginous heat, local burning at beginning.	1. Lesion absolutely indolent no burning or itching.
	2. Lesion habitually multiple.	2. Lesion often single or multiple to a less degree than herpes.
	3. Erosion of small size frequently miliary.	3. Lesions usually larger than herpes.
	4. Erosions usually more superficial than chancre.	3. Lesions usually less superficial than those of herpes.
Errors to be avoided.	Possible coincidence of chancre and herpes.	

But, gentlemen, in some cases, sufficiently frequent, as you have observed, when it concerns solitary herpes with a single erosion, and true chancriform herpes simulating certain dwarf chancres, a part of the signs enumerated above would fail you, and the diagnosis would become very difficult. You have recently seen that genital herpes may react upon the inguinal ganglia. In many cases a painless inflammatory ganglionic swelling is produced, perhaps multiple, but not presenting the specific hardness of the adenopathy from chancre.

In one case, a woman of St. Come, a suppurating adenopathy of the right ingunial fold was produced. In these cases I deem it very important to seek with care for the following characteristics: I have shown you great utility of a sign upon a great number of male and female patients in my wards, which has not hitherto, so far as I know, been pointed out by the authors. (I have a note upon this subject in the Journal des connaissances Medicale, H. Leloir, upon two clinical characteristics of great utility in the diagnosis of syphilis and herpes, April 3, 1885).

Here are the signs: seize a dwarf chancre press it between your fingers as long as you please. You cannot cause more liquid to issue from it than there is ordinarily. It almost seems as the surface was varnished with a layer of liquid. On the contrary, seize a herpetic erosion, solitary herpes, as in the case before you, press it between your fingers and you can make a small drop of serous fluid, transparent and of amber hue, like the serosity of some eczemas, exude from its surface; wipe this away, press it again. You will soon see a new drop escape; cleanse again then press anew, a new drop appears, and it will continue thus.

Gentlemen, you will not observe this in chancre, in this variety of dwarf chancre which may be confounded with this variety of solitary chancriform herpes. Therefore, in chancre there is little or no oozing,and this oozing is not increased by pressure. Once wiped away, it is not produced except with difficulty. In herpes, on the contrary, there is oozing, oozing much more abundant, augmented by pressure, reproduced abundantly by pressure, a great number of times. Gentlemen, you can judge of the value of this sign in the patients who pass before you.

It seems to me this fact can be interpreted in the following way. In herpes, as a result of neuro-paralytic hyperæmia, there is a hyperæmic œdema of the skin localized and intense. Sometimes there is vascular dilatation in the deeper layers of the skin. In chancre there is nothing similar. Here is a hard neoplasm, with vascular sclerosis sometimes. Therefore, when you press the base of the elementary lesion in herpes, you cause the liquid œdema, localized in the skin, the juice of the lesion, if I may use the expression, to escape from the surface of the erosion. In the chancre, on the contrary, there is nothing similar; there is no liquid œdema, there is no juice which you can press from the the surface of the lesion, there is only a hard neoplasm, without expressible juice, so to speak. When the chancre rests upon œdematous tissue, as you have seen in many cases of chancre of the prepuce, the liquid or serum escapes by chancrous erosion. This is a cause of error in diagnosis, which you must guard against, as I have already told you.

Sometimes, gentlemen, as you have seen in some patients in our wards, localized œdema of the skin may produce beneath the herpetic erosion a kind of induration, simulating closely the superficial induration of certain dwarf chancres, the limitation of whose induration may easily lead the clinician into error. But, if you seize the pseudo-induration between your fingers, you will, in time, by strong and continued pressure, succeed in working it up, modeling, so to speak, between your fingers so as to change the form and flatten it. On the contrary, seize the induration of chancre, squeeze it as much and as long as you please, you cannot change its form or model it. We may give to these signs the name of "signs of expression of juice."

The preceding signs, of which I have just given you anatomico-pathological reasons, are applicable to the diagnosis of all syphilomata from the lesions of the skin which simulate them, as I have shown you in a note on the nature and pathological anatomy of polymorphous erythema, published in April, 1884, at the Anatomical Society, Progres Medical, 1884.

Finally, gentlemen, biopsy, by permitting us to make an examination histologically, will be of great utility in the differential diagnosis. We remark in passing that, contrary to what we have seen in simple chancre, the examination of products scraped from the surface of the erosion will not serve in this differential diagnosis, for in the gray syphilitic erosion, as well as in the gray herpetic erosion, there is an epithelial reticulum formed by "cavitary alteration," as the surface of the erosion.

After this long study, gentlemen, you will think you can always absolutely diagnosticate chancre. Well, do not forget the primary syphiloma may closely imitate lesions and lesions imitate the primary syphiloma. Do not forget, if it relates to a case in legal evidence, that, as Fournier has well said, "We cannot diagnosticate chancre by the chancre." The characteristics of the adenopathy themselves are not sufficient to settle a diagnosis, as we shall see. In a word, be careful, and, if a certificate is demanded of you, watch the explosion of secondary accidents before you give an opinion.

THE TREATMENT OF ACUTE AND CHRONIC RHINITIS.

BY A. DE VILBISS, M. D., TOLEDO, OHIO.

Previous to the present method of making examinations of the superior respitory tract (and since by some) all conditions accompanied by discharges anteriorly or posteriorly were called catarrh. Whether from nasal polypus, fibroid, sarcomatus tumor, foreign body, ulcerated or deflected septum, or hypertrophed tissue over the turbinates, there seemed to have been but one name known for the disease. Stenosis, complete or partial, from any cause producing discharge, came under this name and received the routine treatment of irritating injections, douches, caustics and powder locally, with tonics and alteratives internally; this was the course pursued, practitioners knowing little more than the patient as to the cause of the discharge. The result of this mode of treatment was failure. It would have been far better to have only trusted a kind providence for relief. Diseases of this class were, therefore, not long since, considered incurable, not only by the people but by the medical profession, while at the present time they are considered amenable to treatment.

As nine-tenths of the people are suffering from some form of nassal catarrh, it is marvelous that we were so slow in looking into and finding out the pathological conditions which give rise to the difficulty, that now, by appropriate treatment, we greatly relieve, and in a large majority of cases entirely cure in a short time.

In the treatment of these diseases the first important point is to know the cause of the discharge, so that we may map out for the physician and patient what to do. We must not be content with simply assuring the patient of relief, but should seek to know where the trouble lies and through what channel it comes. Understanding the constitutional relations and the nature of the chronic inflammatory conditions of the superior respiratory tract, and the part played by the local causes, it will be readily appreciated that the management must sometimes include both general and local measures. The constitutional includes diet, hygiene and internal medications; while the local includes applications that are protective soothing, astringent, stimulating and removal of tissue, according to the nature of the case. There is not, neither can be, any specific without due reference to the cause of catarrhal inflammation, and there is no remedy nor any course or plan of treatment effective in every case, nor yet in the same case under different circumstances, and, therefore, cannot always be cured or even benefited by the same remedies. The remedial agents, as well as the entire course of treatment, should not be depressing in character, but rather tending to raise the grade of vital action: because there is always a lowered vitality of the parts affected, and very often of the general system. Tonics, stimulants, laxatives, diuretics, are to be used cautiously, as they are not all equally serviceable, nor is any one of them at all times of value. Arsenic, iron, quinine, nourishing food and out-door exercise are of service at the right time; but may do harm if improperly used. The same is true of a stimulating local treatment, which is often applicable to the later stages, but would be very injurious during the acute period. It should be understood that we do not here have reference to an inflammatory condition of the mucous membrane, induced by external irritants alone, but to a definite diseased state, having important though varying connections with the different organs of the body. In certain cases, as urticaria, resulting from temporary disturbance of the system, the trouble disappears under proper local treatment alone, the transitory internal cause having already passed away. But this is to be recognized and determined in each case. The condition (entire) should be taken into consideration, and all departures from health looked into and rectified as far as possible, inasmuch as any one of them may be a sufficient cause of prolonging the disease.

It is difficult, if not impossible, to separate entirely the subject of constitutional treatment of acute inflammation of the throat and nose from that of the chronic stages; for it is the nature of the acute to pass into the chronic form of the disease. Acute rhinitis, as a rule, requires light diet, alkalies, and mild laxatives, with a few doses of quinine to relieve the full and tense feeling and to diminish the congested condition of the capillary blood vessels.

For an alkali, I prefer acetate of potassium; and if there is inaction of the skin and kidneys, combine it with sweet spirits of nitre and spirits mindereri, adding aconite if there be much fever. The local treatment should consist of Dobells or some similar solution, made warm and applied with a spray producer to vaults of pharynx, posterior and anterior nares, to cleanse the mucous membrane of secretion or any substance that may be lodged upon its surface. It may also be necessary to cleanse the fauces and posterior wall of pharynx; after this is done the membrane shoud be thoroughly coated with that which will protect it from irritants that may come in contact with it, and have a soothing effect, as a poultice applied to a bruised or inflamed part. The material used must be harmless to healthy tissue, soothing to the diseased surface, and tend to lessen the inflammation.

I know of no remedy which, as a rule, will accomplish these purposes so well as oleaginous substances, applied evenly and completely to all parts of the irritated membrane, with a spray tube and compressed air, this being the best and only means of successfully reaching all the parts with a substance of sufficient density to serve as a protection without producing so much irritation that the means used would do more harm than the remedy good. In using compressed air as a spray-producing agent, we should be very careful not to have the pressure so high as to produce irritation.

Beverly Robinson, in his most excellent work on nasal catarrh, page 58, edition 1885, says: "Amongst local applications the following are useful: externally over the bridge of the nose, the application of some fatty or other emollient substance, such as cold cream, suet, sweet oil or vaseline. Internally, as a local application to the mucous membrane itself, the same substance may be applied by means of a camel's hair brush, and of these vaseline is the best."

I agree with Dr. Robinson in regard to vaseline being the best internal local applicant, but not in regard to his way of applying it to the parts.

If, instead of a camel's hair brush he had used a spray producer to make the application, he need not have made the statement which appears on page 58, that patients, "will persist in affirming that the remedies are worse than the disease," but could have said that they will persist in affirming that it is the most pleasant and soothing treatment one could desire, and certainly will do good, "I feel better already," as we have had the pleasure of hearing patients say hundreds of times.

To attain any degree of success, the application must be made in a pleasant way. I think there is as much difference in receiving a spray from the hand of an expert, and one untrained, as there is in being shaved by a first-class barber, and a bungler in his line.

Experience is necessary in order that the application may be well made to all parts, and at the same time be grateful to the patient. Infants that do not breathe easily through the nose, and hence are compelled to let go the nipple, may be readily relieved by a few applications of vaseline in a spray form. Of the value of this treatment any one will be convinced by a fair trial; and this is all that is needful to bring it into common use among practitioners.

The necessity for treatment of acute attacks is well known to all who look carefully over the history of chronic catarrh, and remember that it commences by repeated colds in the head, each succeeding cold lasting longer, susceptibility increasing, colds being taken the patient scarcely knowing how, until at last he is continuously affected. Treatment should commence as early as possible, every effort made to lessen the inflammatory condition, and cut short the insidious disease in its early stage. The length of time between cold taking can be increased; and by removing the predisposing cause, we prevent the acute from passing into the chronic form. The prevention of colds in catarrhal patients, who have been affected for years is frequently a difficult task, as the local conditions of the parts incites the renewal of colds.

This condition of susceptibility to acute attacks will eventually disappear under the combined influence of an appropriate course of hygienic, constitutional and local treatment.

The treatment of hypertrophic rhinitis embraces that which will lessen secretion, prevent further thickening of tissue, and removal of that which already exists.

First cleanse the parts; to this I educate the throat by applying vaseline a few times. For if an aqueous solution is used at first, the soft palate will close the door to the vault of the pharnyx and chambers of the nose, the parts that need treatment most. It is exceptional to find a throat that cannot be trained with vaseline, so as to reach every part and in a short time tolerate the use of washing solution; whereas it is exceptional to find a throat which can be thus treated at first.

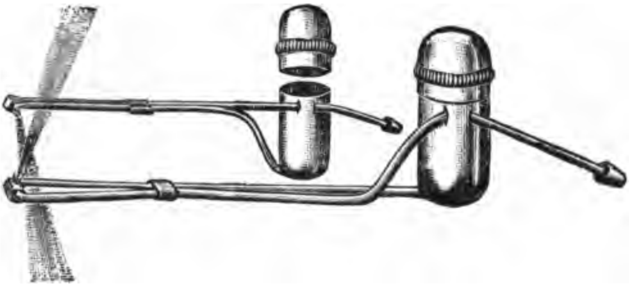
After the parts are accustomed to the spray, I cleanse by applying with spray producer a solution composed of soda bi-carbonate thirty grains, soda bi-borate one dram, oil gaultheria thirty drops, glycerine two ounces, water one pint.

After cleansing, I apply iodol twenty grains to ounce vaseline, or soda bi-borate ten grains to ounce vaseline, etc.

Absorbtion will take place, stenosis be relieved, the secretion thinned, passing off unnoticed as normal, except in cases of too long standing, which may not yield to above mode of treatment. Then it may be necessary to remove thickened tissue by galvano cautery, Jarvis snare or chromic acid. If there be a deviated septum that lessens caliber of nasal cavities sufficient to be an impediment to breathing, straiten it by removing the portion that projects; the best instrument for the purpose is a saw with triangular teeth as constructed according to supervision of Dr. Bosworth, who says: "Any irregularity or projection in the vertical plane of the septum, of enough prominence to interfere even slightly with the free passage of air must, I think, be regarded as an abnormality requiring correction."

In the treatment of the atrophic form of rhinitis, I make application every day of bi-carbonate of soda, one scruple to vaseline one ounce with spray producer, until the patient is so accustomed to receive the applications that every part of superior respiratory tract can be thoroughly lubricated. After which every other day is sufficient for three or four weeks, then twice a week for a month or two; finally once a week until there are no more hardened secretions remaining. As an intermediate treatment I furnish the patient with a spray producer, and teach him how to use it so he will be able to reach every part. Without thus training the throat, and proper understanding of the patient just how to operate the instrument, but little will be accomplished; but with a proper knowledge of what is to be done, and skill of execution, there are none of this class of patients but who can be greatly relieved and many cured.

For a detailed account of the manner of making these applications with a compressed air apparatus (I would refer you to Dr. Rumbold's work on hygiene and treatment of nasal catarrh). I used his spray producer for years, as they were the only instruments by which oleagenous substances could be successfully



applied, but the inconvenience and time required in changing from one to the other to obtain the different directions, led me to construct one with moveable spray-carrying point, so that any part can be treated with one instrument, as shown in illustration.

After accomplishing this I found that by making a small opening in air tube and connecting it to cup in such a manner that the air escaping could be confined on top of fluid, I could get a good spray with rubber bulb, thus having an instrument to put in the hands of my patients for home treatment. The liability to take cold during the fall and spring seasons make it necessary to give a few treatments in order to cut short the cold and relieve the catarrhal symptoms. These fall and spring treatments will need to be repeated from two to five years with the younger and middle aged, while those who are older may expect to repeat them as long as they live. A half dozen colds during the changeable seasons are all that is necessary to bring on the first chronic condition; but if the patient is properly treated at these changes of seasons, the improvement will continue and assume such a permanent character that they may pass for years without a cold requiring treatment.

This may seem an unsatisfactory result, but when we consider the train of inconveniences and annoyance that accompany chronic catarrh, and the miserable life which many persons are obliged to lead on account of it, we have certainly accomplished a great good. When the young are cured and the old are relieved of all the most unpleasant and dangerous condition, as much is accomplished, indeed, as is possible in many other diseases. We can only hope to give comparative relief from that which, untreated, renders life miserable and unpleasant to those around us.

This class of patients must oftentimes be content with a reduction of their troubles, and not expect to be entirely and permanently cured.

CORRESPONDENCE.

A CASE OF ABDOMINAL TUMOR WITH ASCITES.

Editors MEDICAL GAZETTE.—In the February number of the MEDICAL GAZETTE, I was much interested in the editorial upon the malpractice case, and I was somewhat surprised at the opinions given by the best medical authorities of your city. I will relate a case that came under my observation. I was called to visit Miss A. E., a young lady of twenty-two years. She had been treated by Dr. McKenzie of Litchfield, of this county, for a number of weeks. Her abdomen began to enlarge, and I was told the doctor made an examination and pronounced her pregnant. Miss E. said to him: "I know you are mistaken, for if it was so I ought to know it, and I know you are wrong." The doctor persisted in the correctness of his diagnosis and told her mother that he could feel the skull of the child. Miss E. was offended; the doctor dismissed, and I was called December 21, 1863. I diagnosed the case ascites and ovarian tumor of left side. The tumor was easily felt. I did not think it best to remove the water. Gave her treatment; saw her once in eight or ten days, up to February 18, 1864; all this time she was about the house doing light work; her respiration short. I decided on the withdrawal of the fluid. Having no trocar or canula, I took the best instruments I had—a thumb lance and female catheter. I placed her on her right side, made a half inch incision through the skin, punctured with point of lance, inserted catheter, and drew thirty (30) pounds of a light colored fluid; drew the wound together, put on adhesive plaster. Healed in two days, and she was relieved. The tumor could be easily felt through the parietes. She was around the house in two or three days at her usual work. The water accumulated slowly, but May 1 her breathing was a little short. I observed the same mode of action, and drew off thirty (30) pounds again, the tumor increasing a little; recovered as before. I will omit the details of the case between the operations to evacuate the fluid:

July 11	removed 31 pounds
September 15	removed 34 pounds
December 6	removed 32 pounds
February 10, 1865	removed 33 pounds
March 23	removed 32 pounds
April 7	removed 34 pounds
May 21	removed 31 pounds
June 12	removed 35 pounds
July 1	removed 31 pounds
July 21	removed 31 pounds
August 12	removed 30 pounds
August 31	removed 35 pounds
September 27	removed 36 pounds
October 12	removed 37½ pounds
November 1	removed 37 pounds
November 23	removed 38 pounds
December 9	removed 39½ pounds
December 25	removed 37½ pounds
January 12, 1885	removed 39 pounds
January 29	removed 38 pounds
February 16	removed 37½ pounds
March 7	removed 50¾ pounds
March 28	removed 44 pounds
April 10	removed 44 pounds
April 6	removed 36 pounds
May 14	removed 43½ pounds
May 31	removed 43½ pounds
June 19	removed 48 pounds
July 6	removed 41 pounds
July 24	removed 46½ pounds
August 10	removed 37¾ pounds

My operations or openings were made anywhere within one inch of the umbilicus; at last had to puncture in the old scars. She was a light built girl; would weigh in health one hundred and ten; was somewhat emaciated at death. I saw nothing unusual the last time I operated, but was called back two days after and found pulse one hundred and twenty, skin hot, tenderness over the abdomen; died four days after the operation. Post-mortem one day later, in company with Dr. Carpenter of Litchfield. We found the left ovaria in size, ten inches in length, six inches in diameter, with a number of cyts, from the size of a filbert to that of an egg; it was mostly of a fibrous character. The pedicle, one inch in diameter. We found no other organs involved. I repeatedly urged her to have it removed; she would not listen to it. What caused the ascites and rapid accumulation of such quantities of water? Was it malignant or non-malignant? The peritoneal coat was of a pale pink color.

The case may have no interest to city doctors. I can't reconcile some of the testimony in the case of your editorial. I have met Drs. Herrick, Vance and Weber. Thayer was a classmate of mine in 1848–9. Excuse me for trespassing upon your time.

Fraternally,

A. G. WILLEY.

Spencer, Medina county, O., March 10.

Editors GAZETTE: Will you permit me, through your columns, to correct a misapprehension you labor under, and so convey to your readers, as to my part in the case of which you speak in the editorial entitled "A Suit for Alleged Malpractice"?

Referring to the charge twice made before the Medical Society by Dr. Herrick that the death of the patient resulted from the operation performed by Dr. Vance—Dr. Hart not being mentioned—the editorial says:

"Notwithstanding these strictures must have been very irritating to Drs. Vance and Hart, they would not be justified in retaliating by agging on a suit for malpractice. Although there was no evidence brought forward during the trial to show that these gentlemen were instrumental in instigating the suit, it is the general belief that it could have been prevented by them. We cannot censure too severely any one who, to gratify personal spite, will cause the fair name of our profession to be brought into disrepute."

How was it proposed that Drs. Vance and Hart should prevent the suit? In my testimony in the case the attorneys drew out the following statement: That at Dr. Herrick's request I went to his office, and with him to the office of Dr. Vance; that there Dr. Herrick said that Drs. Vance and Hart could stop the suit if they were disposed to do so; that when I inquired in what way we could do it, he replied: "By saying to the parties or their attorneys that we would not support them in the suit by our testimony; that I replied that since the day of the post-mortem I had never seen the parties or been approached by any one in regard to the suit, and did not know that they proposed to call me as a witness, and that it would be preposterous for me to interfere in the case. The plaintiff in the suit and his wife both testified that Dr. Vance had not encouraged the suit, as did also Dr. Vance himself. Dr. Hart testified that he had said that he did not think they had a case, in law, against Dr. Herrick. And as I never encouraged the prosecution by word or deed, and held no communication with any party concerned in it until called as a witness, I am at a loss to understand the grounds on which it can be supposed that I could have prevented it.

A. G. HART.

37 Jennings Avenue.

The Cleveland Medical Gazette.

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A. R. BAKER AND S. W. KELLEY, *Editors.*

EDITORIAL.

"SUBSTITUTION BY DRUGGISTS."

We are pleased to see other journals devoting attention to the relation of doctors and druggists, and hope that the subject will be so thoroughly discussed that every medical man will give his efforts toward the correction of existing abuses. We reprint the following from the St. Louis Medical and Surgical Journal:

> There was a time when there was no intermediary between the physician and his patient—when every doctor dispensed his own medicines. In cities and closely settled communities this practice gradually became burdensome, and was relegated to a special class, the druggist or pharmacist; but the old-time custom is still adhered to very largely among rural or country physicians.
>
> When the "patent medicine man" made his appearance, this agent, or intermediary of

the physician, promptly assumed the same position towards the intruder, and united to his honorable calling of pharmacist the less honest but probably more profitable one of vender of nostrums. This anomaly would have adjusted itself in time, and, indeed, has already partially done so, but the druggist has been deflected from the straight and narrow path. Aiding a fraud, what more natural than that he should, in certain instances, become imbued with the spirit of fraud? Seeing the gullibility of the public, and knowing the profits accruing from the trade in nostrums, the less honest and more avaricious of the guild were henceforth but ill-content with the comparatively meager profits of their honorable and legitimate calling. The outgrowth of this spirit was the crying evil of substitution—the replacement of high-priced ingredients in prescriptions by others less costly and totally inefficacious. There is scarcely a physician in our cities and towns who has not at some time had good reason to complain of this evil.

Of late, the rascally practice has taken a wider range in a direction made possible by the legitimate advance of the art of pharmacy. We refer to substitution as applied to those products of chemical and pharmaceutical skill, aided by abundant capital, known as "proprietary preparations"—preparations, the nature and ingredients of which are made known to the medical profession, for whose use alone they are manufactured, and which are by no means to be classed or confounded with "patent medicines." Many of these proprietary medicines are of great value commercially, and, as a result, they are composed of the purest drugs, compounded with great skill. A certain proportion of the medical profession (and some of them men of wide and honorable reputations) have found these preparations good and useful, and their exhibition attended by most satisfactory results; and, hence, have prescribed them largely, not the least potent reason for this fact being the feeling of security against substitution induced by the careful and often costly methods of package adopted by the manufacturing chemists. But, as "love laughs at locksmiths," so laughs the substituting druggist at seals and wrappers of unique design, at signatures and brands; and the manufacturing chemist, who spends thousands and hundreds of thousands of dollars in keeping up the standard of his preparations, finds himself suddenly accused of allowing them to deteriorate, or possibly of sophisticating them for greater gain.

Without referring to them by name, we may say that very recently a number of the great manufacturing houses have found themselves in this unpleasant position; and, in every instance where investigation was possible, the fact was disclosed that the apparent deterioration was due to the dishonesty of the retail druggist or prescriptionist, who had substituted his own worthless compounds for those ordered by the physician.

Such substitution is not simply dishonest; it is felonious, and displays the same reckless disregard for life that marks the burglar or highwayman who is prepared to take a life if it stands in the way of his plunder. The man who does it does not simply filch a few cents from the pocket of his customer (frequently poor and needy), nor does he merely jeopardize the reputation of a physician, but he puts in peril the life of the customer who trusts him.

The honest members of an honorable profession, and fortunately they are largely in the majority—the reputable pharmacists—owe it to themselves to expose these vultures and drive them from the trade. In doing so they should have the aid and countenance of every physician. In the meantime, let every physician not content himself with shunning the shops of those whom he detects in the nefarious habit of substitution, but boldly denounce them, and warn his patients against carrying prescriptions to them. Concerted action of this sort will soon purge the trade of the offending members.

A case in point is that recently begun in Chicago before Judge Blodgett of the district court. The action was brought on behalf of the Austrian government and the city of Carlsbad through their attorneys and their authorized agents. The Eisner & Mendelsohn Company of Philadelphia, against John Ritter, wholesale manufacturer of drugs and chemicals. The bill recites the history of the mineral springs which are the sole property of the city of Carlsbad, in the empire of Austria, who leased the rights in the year 1877 to Loebel Schottlander in consideration of 175,000 florins." The bill then continues with an account of the world-wide reputation of the waters and of the Sprudelsalz prepared from the waters, and describes the business, the product, prices, the trade marks and copyrights, method of packing, etc., carried on by Schottlander, and charged the defendants with "engaging in a systematic fraud and conspiracy to sell spurious material as genuine, and in addition counterfeiting in exact *fac-simile* certain cases, bottles, caps and wrappers composing the valuable trade marks" of the prosecuting parties. The bill then sets forth the damage done, both indirectly by dissatisfaction and loss of reputation on account of the use of spurious articles, and directly by the taking away their trade and selling the counterfeit goods at lower rates than the rightful manufacturers obtain for the genuine, and prays for compensation, damages and a "writ of injunction forever restraining the defendants, agents, clerks, servants and workmen from in any manner selling the said Carlsbad Sprudelsalz and using or imitating your orator's peculiar marks, labels and designations." A temporary injunction was granted.

There is also a bill in equity filed in the circuit court of the United States for the district of Maryland, wherein the same complainants bring substantially similar charges against the Charles A. Vogeler Company, Baltimore, of patent medicine notoriety. It appears that the defendant in this bill, "in addition to falsely and fraudulently representing the artificial production put up and sold by the said defendants as the genuine imported Carlsbad Sprudelsalz, the said defendants falsely and fraudulently assert, upon the labels placed upon the said bottles, the following words: "Directions inside. For sale by all druggists. None genuine without the signature of the undersigned, sole agents for the United States. The Chas. A.

Vogeler Company, Baltimore, Maryland. Beware of imitations." Whereas, the defendants are not now and never have been sole agents for America or the United States. Such practices trot in harness very well along with the patent medicine business.

A gentleman recently, at our suggestion, secured three specimens of Sprudelsalz from as many drug stores in our city, and two of these were found to be spurious, consisting simply of washed sulphate of soda—a white, fine powder—while the genuine Sprudelsalz is of an entirely different chemical composition—a yellow, coarse crystal. If space permitted we might cite other cases of equally flagrant frauds perpetrated by dishonest druggists.

MEDICAL FEES IN CLEVELAND.

Medical fees are lower in Cleveland than in any other large city in the United States. The profession is over-crowded every where, but nowhere so noticeably as in cities containing several medical colleges. And this is especially true of Cleveland. It is the glory of our democratic institutions that men can enter the learned professions from any station in life. But this has its attending evils, particularly in the medical profession, where schools of learning depend for support wholly upon the fees of the students; and the fees have been kept low as a bid for large classes, and the course of study is as "lenient as the law allows," or rather as the absence of law allows.

It is a fact that of late years more men have entered the profession from the lower strata of society, socially, mentally, morally and financially, than ever before. The result is that many graduates being obliged to earn their own living from the first year they commence practice, or if possessed of means, being desirous of attaining some social standing by a show of professional success, render their services for whatever they can get. It is these who, being meagerly equipped either with money, with education, or with moral stamina, must go to the wall or resort to quackery. This state of affairs has been so long in operation in our city that people expect their medical attendant to charge them a dollar a visit and often will not pay more.

It is but a few years since our city was but a country village, and we had those grand good men DeLamater, Kirtland, Ackley and others, who loved their profession more than money. They founded our medical schools on a cheap basis, because the city and country were poor. They were governed by the same circumstances in their practice and charged low fees. Now the city has become large and rich, and the State has prospered likewise. But the medical profession has been governed by the traditions of their illustrious predecessors, and have not increased their fees in proportion to the growth of the community and the increased demands made upon the doctor's purse. These remarks apply to fees in practice and also to the medical colleges to some extent.

Another drawback to the profession here is the fact that we have no consulting physicians and surgeons, generally known to the profession as such. We have men of wide experience, extending over thirty or forty years of active practice, who continue to visit tenement houses at a dollar a visit, and are called out to attend to midwifery cases at all hours of the night; who, instead, ought to be doing a consultation practice, reaping the reward, in large fees, of their years of toil, and conferring on the younger men in the profession the benefit of their ripe experience.

We hear it frequently alleged that there is no one in the city of wide experience in general practice whom the young men can call in counsel, and feel perfectly sure that nothing will be said or done to lessen the confidence of the patient and family in his ability properly to manage the case. It is even said that when some of the seniors are called in counsel it is about equivalent to the dismissal of the attending physician. On the other hand, it is complained by those whose advice is sought in counsel, that they are seldom requited with a prompt or adequate fee. Their time is consumed and their best skill exerted for a meagre and tardy fee, or for empty thanks. This matter of the consulting fee is in the province of the attending physician to remedy by a timely word to the patient or his family beforehand.

Another great obstacle to professional success here is the method adopted by some of charging by the week. We know of one who does a practice which ought to be worth twenty or twenty-five thousand dollars a year from which he does not realize five thousand, simply because he has fallen into the habit of charging small fees—such as one or two dollars a week for services rendered at the office every day.

We are told that there are specialists here who fit spectacles for one, two or three dollars, much less than is charged by our opticians, who have no special training, and whose skill and time are worth no more than those of an ordinary salesman. And we know of one practitioner whose usual fee for introducing a pessary is from one to two dollars and furnish the pessary. Then we have a few who are pretty well known to their professional neighbors by their practice of appropriating business by means of underbidding. For instance, a lady patient is informed by her medical attendant that she can never be entirely relieved until she has an operation performed upon her lacerated cervix or perineum, which operation will be worth fifty dollars. She says she will consider it and make up her mind, and disappears. After some weeks or months the physician accidentally meets the patient or some of her family or friends and is informed that the operation has been performed. The patient had consulted Dr. Cormorant and he said that certainly the operation ought to be made, and he would do it just the same or better for twenty-five dollars.

It is sometimes amusing to witness the surprise with which residents of our city will tell of the fees they have been obliged to pay in other cities. The other day a Cleveland gentleman suffering from phthisis had occasion to visit New York, and thought while there he would consult a New York doctor. By the advice of friends he was directed to an ordinary, everyday doctor whose name is not known to fame, and who also would not be so likely to charge a large fee. He was examined by the metropolitan physician, given the same advice which he had received at home for a dollar or two, and charged the modest fee of fifteen dollars, which nearly took the Clevelander's breath away; but he was even then scarcely convinced that some of the greater lights would have charged him twenty-five or an hundred dollars for the same advice.

In contrast with this we might cite a recent case which fell under our observation. A patient from a neighboring city consulted one of our most eminent surgeons for a tumor of the breast. After carefully examining the case, he charged a fee of ten dollars, and apologized for the amount of it and said that if she wished it removed he would do so without any more expense. And actually did.

The evils which we have pointed out all have their remedies, and it is in the province of the profession to apply them. Low fees and lax collections only cheapen the profession in the eyes of the public. Such methods as we have described degrade our calling to a mercenary trade, and not only drag down its reputation but its actual scientific capability. The physician, to work efficiently, should have a comfortable living—less harassed than are the majority by the question of ways and means—he should be able to provide himself amply and to his satisfaction with books and instruments and appliances for study and practice, and not be, as many are, heavily handicapped by poverty through their whole medical career.

The same remarks apply to colleges. Let patients who are too poor to pay be sent to the clinics, where their cases can be utilized for teaching purposes. Let the colleges furnish the community with a physician fitted to the position he assumes in society. Let the physician serve the people skillfully and faithfully, and let the people reward the physician with respect and with money—and at the present day, in Cleveland, the people will not bestow upon the medical man a smaller modicum of respect if required to contribute for his services a more adequate emolument in ready cash.

"SAD CASE OF INSANITY.

"A YOUNG MOTHER BECOMES A RAVING MANIAC AFTER THE BIRTH OF HER CHILD.

"A. B., wife of a wealthy young farmer living a few miles south of this city, gave birth to a child last Wednesday. She was an amiable, accomplished young woman, widely known and highly connected. When the baby was presented to her she became a raving maniac, and was furious until the child was removed. The next day she tried repeatedly to throw the child into the grate fire. Afterwards she nearly succeeded in an attempt to dash its brains out, and her husband and friends were obliged to recognize the fact that she was dangerously insane. The case is thought to be incurable. She was taken to the Warren Insane Asylum yesterday."

The foregoing is clipped from a Pennsylvania newspaper. This is the second time within a few months that we have heard of cases evidently of puerperal mania, which are promptly decided to be incurable and the patient hurried into an asylum. It seems necessary to counsel medical men to longer deliberation before making such a gloomy prognosis and subjecting a patient and her family to the lasting stigma of an incarceration in an insane asylum. Here is a woman within a few days after her confinement, when she is not fit to be out of bed, carried off on a journey to an insane asylum. It might be necessary, if the surroundings were such that the patient could not be cared for at home, to remove her to an asylum or hospital where trained attendants could have her in charge, but it would surely be an exceptional case that could so soon be pronounced incurable. There are but few cases of puerperal insanity that do not recover. In the majority of cases it would be more advisable to procure attendants to take care of the patient at home for a time until the effect of medical treatment could be tried, and at least till the first few weeks following the confinement had passed.

The stage of acute mania is not likely to continue for any great length of time, and it would seem that any intelligent physician ought to be competent to handle such a case properly where the circumstances of the patient could command suitable nursing. If, later on, the case was drifting into melancholy, which is usually more difficult to manage, it is often best to remove the patient to other scenes, where the agents most favorable for her recovery can be obtained.

LITERARY NOTES.

Books and periodicals sent to the "Literary Department" of the GAZETTE, 143 Euclid Avenue, Cleveland, Ohio, will be acknowledged, examined, and if meritorious, carefully reviewed.

Any book noticed below can be obtained through the nearest book store or through this office.

Periodicals noticed in these columns will be furnished to subscribers of the GAZETTE at 10 per cent. less than regular subscription rates.

Man is naturally a religious being. There is a "light which lighteth every man that cometh into the world." Hence, among all peoples are found certain superstitions or beliefs upon which is built a religious superstructure depending largely on their intelligence. It is, therefore, important that they should be familiar with the principal religions of the world and be able to intelligently discuss them.

No one has too much faith in "the things that be" in his fellowmen or in himself. Though a physician be naturally a credulous person, he soon, from study and observation, tends to become one of the opposite character. It requires an effort to maintain his natural condition. If this is not made, his belief in an immortality disappears and death means total annihilation.

I am one of those who believe that to serve one's fellowmen is not the essence and end of religion. I believe in a religion which has in addition to this a spiritual something, a duty to God, a faith in a futurity—unknown and undemonstrable, it is true, but, nevertheless, an entity.

One of the new religions—more properly a revival of an old one—is "Theosophy." Among the many discussions of this system of "Theosophical Ethics," there have come to my desk two works of about a hundred pages each, which I have read with pleasure and profit. They are 'Can Matter Think? A Problem in Psychics,' by F. T. S., and 'Kuthumi, The True and Complete Economy of Human Life,' by Elliott Cones. They are Nos. 4 and 5 of "The Biogen Series," published by Estes & Lauriat of Boston, and edited by Professor Elliott Cones of Washington, who is too well known as a scholar to need words of praise from me. The "series" consists of concise essays on the live questions of the day, and on religion, science and philosophy by writers of the most eminent ability. For one wishing to understand this system, which is so much discussed now by thinking people, I can heartily recommend this "Biogen Series." In addition to the thought, the type is clear, the margins wide, the size convenient and the binding flexible, all of which add to the comfort, and, I might say, pleasure of the reader.

From the same firm, Estes & Lauriat, Boston, noted for the elegance, as well as the scholarship of their publications, comes Carlyle's 'The French Revolution,' in two volumes of 400 and 420 pages respectively. I need say nothing as to the matter of the work in question. It is known to you all. The binding is one of the attractive features. It is in rich *gen d'arme* cloth, lettered in gold. The firm publishes all of Carlyle's works in this style, a most elegant one for those who cannot afford fine calf and morocco bindings.

Have you read 'Miss Toosey's Mission,' 'Laddie' and 'Tip Cat'? If not, secure them at once. I do not know the name of the author. They are not long volumes. You can read any of them in a little while. You can carry one in your pocket and read it in odd moments, but I fancy you will not be able to turn from the pages until you have read every line. 'Laddie' is especially interesting to physicians. It takes them through the hospital wards and to the bedside of the sick and dying. It seems to me that no one can read these little books and not be better by reason thereof. The first two named are published by E. P. Dutton & Company, New York, the last by Roberts Brothers, Boston.

Speaking of carrying one of these in your pocket, reminds me that that is an excellent habit to always have some reading matter about your person in the form of a small volume or some verses of poetry. Many moments—and in a year many hours—are lost waiting for trains, for consultants, for people who are behind time, etc. These could be well employed and our stock of knowledge added to by always "having something along to read." The plan is not original with. I learned it many years ago from a college professor, who also disclaimed any copyright upon the plan, and I'm quite sure that one-half of the poetry I know has been committed during these times of enforced idleness.

S. M. F.

NOTES AND COMMENTS.

ANNUAL MEETING, CUYAHOGA COUNTY MEDICAL SOCIETY.

At the annual meeting of the Cuyahoga County Medical Society, held April 7, the following officers were elected for the ensuing year: President, Dr. P. H. Sawyer; first and second vice-presidents, Dr. D. P. Allen and Dr. W. T. Corlett; recording secretary, Dr. S. W. Kelley; corresponding secretary, Dr. A. B. Carpenter; treasurer, Dr. J. C. Preston; censors, Drs. I. N. Himes, C. Hintzelman and A. J. Cook. Dr. Himes was reëlected as trustee. On motion, Drs. Cushing, Allen and Himes were reappointed committee on library. A committee consisting of Drs. Carpenter and Corlett, was appointed to suggest Reports and Reporters on Progress for the year, and made the following report, which was adopted: May meeting, Phys. and Path. Hist., Dr. C. Sihler; June, Jurisprudence, Dr. C. C. Arms; July, Practice of Medicine, Dr. W. J. Scott; August, Throat and Nose, Dr. A. R. Baker; September, Nervous System, Dr. H. K. Cushing; October, Obstetrics, Dr. H. H. Powell; Nov., Dermatology, Dr. W. T. Corlett; December, Gynecology, Dr. A. B. Carpenter; January, Surgery, Dr. D. P. Allen; February, Mat. Med. and Therap., Dr. J. M. Lathrop; March, Diseases of Children, Dr. H. A. Schwendener; April, Ophthalmology, Dr. B. L. Millikin.

The retiring president, Dr. H. H. Powell, delivered his address, taking as a subject "Dietetics in Disease." On motion, the society tendered to Dr. Powell a vote of thanks for his able and interesting address, with the request that he allow it to be printed in the CLEVELAND MEDICAL GAZETTE.

Owing to the lateness of the hour, Dr. Carpenter was permitted to read by title his Report on Progress in Gynecology, with the understanding that it be sent to the GAZETTE, so that all could read it.

A resolution was passed that the treasurer notify all members in arrears for dues for two or more years, that unless paid within three months their name will be dropped from list of members.

Dr. E. P. Hawley was appointed essayist for May meeting, and Drs. Vance and Dutton as leading speakers, the subject for discussion to be "Deformities of the Pelvis."

THE CAUSE OF PROFESSOR SCHROEDER'S DEATH.

The sudden death, recently, of Professor Schroeder, the eminent Berlin gynecologist and obstetrician, created much surprise in the medico-scientific world, as he was younger than most o his colleagues, in the prime of life, and apparently with a brilliant future before him.

A post-mortem examination, which was made by Virchow himself, gave some very decided results. In the brain, near the right lateral ventricle, an abscesss was found. It was encapsuled, about the size of a walnut, and had eventually emptied into the ventricle, where it had occasioned a profuse hemorrhage and an acute inflammation, with fatal results. Another somewhat older abscess was found on the other side of the oesophagus, near the stomach. The cause of these abscesses is abscribed to the blood-poisoning contracted by the deceased in the following way: About six years ago Professor Schroeder performed an operation, and during this operation was unfortunate enough to have a particle of putrid pus fly into his eye. Notwithstanding the instant cleansing of the eye, violent inflammation set in, followed by an inflammation of the whole face, and finally concentrating itself in a pneumonia. Professors Leyden, Frerichs and Lenators treated him, and of the three Frerichs alone considered his trouble not a pneumonia, but tuberculosis, which, by the way, the postmortem failed to confirm, Virchow pronouncing the lung tissue perfectly sound. After a very slow recovery he was sent to Cairo, from whence he returned apparently completely cured. This was five years ago. Since then he has had frequent attacks of fainting spells, which was ascribed to weakness and the like. He was frequently warned to take care of himself, but his genius gave him no rest.

Last winter he became ill once more, and was sent to Nice. In November of last year he again showed very threatening symptoms, but quickly rallied, until about two weeks before his death, when symptoms of a severe brain-lession again threw him upon the sick bed. The symptoms were now so complicated and vacillating, the condition of the patient so changeable, that the attending physicians, Leyden, Gerhard and Westphal, could not make an exact and definite diagnosis. They all coincided that there was present a severe brain trouble, but further on the diagnosis wavered between a brain-tumor, an abscess and a inflammation of the membranes of the brain. The postmortem resulted in the sad disclosure that it had been an abscess of the brain, and that the distinguished physician and instructor had fallen a victim to his calling. H. F.

Practical Prescriptions.

For spasmodic cough, accompanying bronchial or laryngeal irritation:

℞ Sanguinarina Nitrate (Merrell's) Grs ii.
Simple Syrup.
Hot Water, ad f ℥ ii.

Dissolve the salt in the hot water and add the syrup.

Sig: One-half to one teaspoonful every one to three hours.

This will be found a most excellent prescription in those peculiar cases of spasmodic coughs resulting from laryngeal or bronchial irritation, or congestion, and in which the paroxysms are so likely to occur just after resuming a recumbent position.

Sanguinarina is a remedy the value of which is not generally appreciated in *Bronchitis*, *Laryngitis*, *Pneumonia*, etc. Its action in *spasmodic* and *true croup* is so prompt and reliable as to make it esteemed as almost a specific in such cases.

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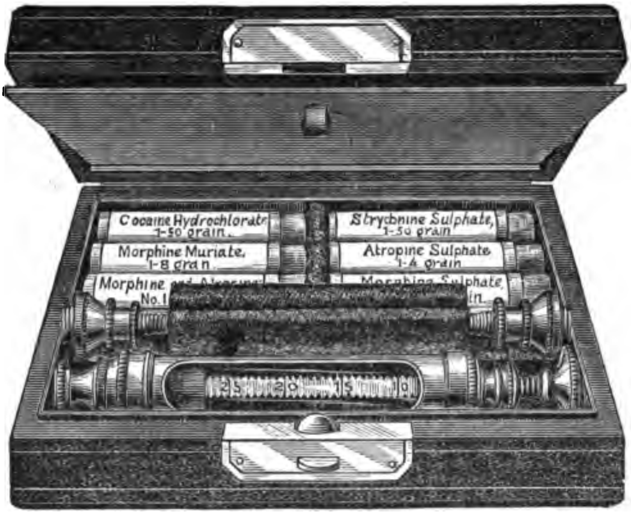

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This Hypodermic Syringe is designed for the use of soluble tablets, and is so constructed that the tablet can be dissolved in the Syringe conveniently. This method of hypodermic injection is becoming very popular for the reasons that a perfectly fresh solution is secured as well as accuracy of dosage. Besides these advantages, the physician can carry a number of varieties of tablets without materially increasing the size of his case. The case shown above is only 3¼x1⅞x¾ inch, and contains besides the Syringe and two Needles, 6 tablets of each of the following kinds :

Morphine Muriate, 1-8 gr.
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The method generally adopted in using this Syringe is to remove the cap at the bottom of the Syringe ; draw in water enough to partially fill the barrel, then drop in the tablet, screw on the needle and make the injection as soon as tablet is dissolved.

The Syringe is graduated on the piston rod so it can be used with solution if necessary. Net price, $2.50.

No. 18, Hypodermic Syringe, is put up in very neat and compact nickel plated case, ⅜x1¼x½ inch. Besides the Syringe and two Needles, the case contains 20 tablets of Morphine Sulphate ¼ gr. In other respects the same description will apply to this Syringe as to No. 16. Will be sent upon receipt of net price, $2.25.

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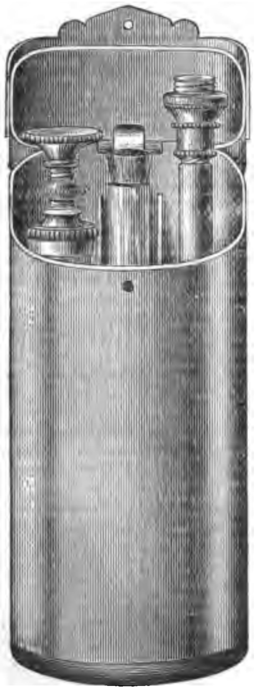

No. 18.

Bellevue Hospital Medical College.

CITY OF NEW YORK

Sessions of 1887-88.

The **Regular Session** begins on Wednesday, September 21, 1887, and ends about the middle of March, 1888. During this Session, in addition to the regular didactic lectures, two or three hours are daily allotted to clinical instruction. Attendance upon at least two regular courses of lectures is required for graduation.

The **Spring Session** consists of recitations, clinical lectures and exercises, and didactic lectures on special subjects. This Session begins about the middle of March and continues until the middle of June. During this Session, daily recitations in all the departments are held by a corps of Examiners appointed by the Faculty.

The **Carnegie Laboratory** is open during the collegiate year, for instruction in microscopical examinations of urine, practical demonstrations in medical and surgical pathology, and lessons in normal histology and pathology, including bacteriology.

For the annual Circular and Catalogue, giving requirements for graduation and other information, address Prof. **Austin Flint**, Secretary, Bellevue Hospital Medical College, foot of East 26th street, New York City.

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Polyclinic.—H. J. Lee, M. D.; J. H. Lowman, M. D.; D. P. Allen, M. D.; D. B. Smith, M. D.; B. L. Millikin, M. D.; C. B. Parker, M. D.; S. W. Kelley, M. D.; H. H. Powell, M. D.; W. T. Corlett, M. D.

The Winter Session for 1887-'88 begins on Wednesday, September 21, 1887, and closes March 7th, 1888. The Spring Session of recitations, lectures and clinics, begins the first Wednesday in April and continues twelve weeks.

The plan of instruction during the Winter Session includes didactic and clinical lectures and operations, recitations, quizzes and practical demonstrations.

Commencement occurs March 9, 1887. Annual meeting of Alumni Association to be held at 2 p. m. on commencement day. Fees—General Ticket, $75.00 Further information upon application to

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We request a trial of the EMULSION, a sample of which will be sent free on application, and solicit a Microscopical test and comparison, as regards subdivision of oil globules, with any or all Cod Liver Oil combinations now on sale.

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SESSIONS OF 1887-88.—Spring Session begins second Tuesday in April; ends last week in June. COURSE—Didactic and Clinical Lectures, Recitations and Laboratory Practice. FEE –$25.00, (credited on General Ticket to those who attend during the ensuing regular session.) MATRICULATION FEE—(good for year), $5.00. Regular Session begins Tuesday, Sept. 27, 87, and ends in last week of March, 1888. Four Didactic Lectures daily, and two hours daily devoted to Clinical Instruction. PRACTICAL COURSES in CHEMISTRY and MICROSCOPY. Attendance upon two Regular Courses requisite to graduation. A three years Graded Course also provided. College Building, new and commodious; ample accommodations for 250 students. The College Dispensary, and the WESTERN PENNSYLVANIA HOSPITAL adjoining (200 beds), afford unexcelled opportunities for Clinical Study. Fee for Regular Course—$100.00; Dissection Fee (including material)—$10.00; Graduation Fee—$25.00.

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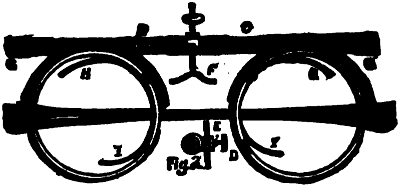

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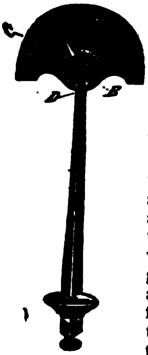

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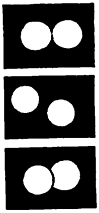
Its operation will be readily seen by the following illustrations. The instrument is fixed to a table; a board fifteen inches square, with black background, on which s a white disc about five inches in diameter, is placed at a distance of say 15 feet.

The patient is directed to look at the white disc through the instrument.

There will apparently be two discs visible to the patient, just touching if the eye is normal.

The Hypermetropic eye will see them separated and the Myopic eye will see two discs lapping.

The great value of the instrument is in diagnosing quickly the most complex cases, as each meridian of the eye is examined separately by rotating the index finger C.



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